RxAmerica Prior Authorization Request

Date:
Patient's name:
Patient's AHCCCS ID number:
Physician's name
Physician's phone number: ()
Physician's fax number: ()
Drug and dose requested:
Formulary agents already tried:
Rationale for request:
Please provide copy of chart notes.
FAX REQUEST TO RxAmerica AT (801) 961-6295
FOR OFFICE USE ONLY
FOR OFFICE USE ONL I
Approved Denied Pending Pending
Rationale:
Received: Physician Notified: